

Division of Medical Assistance  
Local Education Agencies

Effective Date  
Revised Date:

October 1, 2004  
September 28, 2006

## Certification of Non-Federal Match Form (To be used to certify Fee-For-Services)

**INSTRUCTIONS:** Complete items 1 through 4 below, sign and date, and return the form to the address at the top of the second page. Please refer to your Remittance Advice - Total Paid Claims section when completing this form.

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SCHOOL SYSTEM \_\_\_\_\_

MEDICAID PROVIDER NUMBER \_\_\_\_\_ QUARTER: \_\_\_\_\_  
(MO/YY – MO/YY)

1. TOTAL MEDICAID ALLOWABLE \$ \_\_\_\_\_

\*Note-This amount should come from the RA – Total Paid Claims-  
in the Payable Charge Column

2. TOTAL MEDICAID RECEIPTS  
(Amount Received - FEDERAL SHARE ONLY) \$ \_\_\_\_\_

\* Note – This amount should come from the RA – Paid Amt. Column

3. **NON FEDERAL MATCH REQUIRED = (#1 – #2)**  
(State Funds that the school must Identify) \$ \_\_\_\_\_

**4. NON FEDERAL MATCH FUNDS provided by school.** Designate the source and amount of funds in your school budget that you are using to match the federal funds received from Medicaid. The total amount of the state funds that you identify must equal the amount shown in item #3 above.

SOURCE	AMOUNT
_____	\$ _____
_____	\$ _____
_____	\$ _____

*I certify that, to the best of my knowledge, the Non-Federal Match identified in #3 above, for the Quarter ending \_\_\_\_\_ represents actual expenditures accumulated. The certified amount does not duplicate any Federal claims for reimbursement, nor are the funds used to match other federal funds, unless expressly allowed by federal regulation.*

*For any quarter in which the school system is or will be seeking reimbursement for any Medicaid administrative activities that are related to the delivery or coordination of Medicaid screening, diagnosis, or treatment services, I certify that the school system has a Medicaid remittance advice on file documenting that there were Medicaid allowable paid claims for services that were actually delivered to children during that quarter.*

CERTIFICATION OF FUNDS BY \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of School Fiscal Budget Officer

Name (Please Print) \_\_\_\_\_

Title \_\_\_\_\_

**RETURN THIS COMPLETED FORM TO:**

**DHHS – Division of Medical Assistance  
Attention: Budget Management  
2501 Mail Service Center  
Raleigh, NC 27699-2501**

The Local Educational Agency (LEA) may bill Medicaid for health related services and are eligible to be reimbursed the federal share only of the Medicaid allowed amount. The LEA's are responsible for "matching" the federal payment with state funds already in their budgets. This involves identifying what state funds in the school budget are being designated to match the federal Medicaid payment received by the school.

Each LEA must certify the availability of the matching non-federal share of service payments. All LEA's being reimbursed for Fee for Services (FFS) must sign and submit a "Certification of Non-Federal Match Form" to the Division of Medical Assistance to certify Fee for Service. This form should be submitted to DMA for expenditures incurred in a calendar quarter (Ex: Jan-Mar, April-Jun, July-Sept, Oct-Dec).

**Procedure for Completing the Fee for Service Certification Form**

1. **Total Medicaid Allowable** - All costs that Medicaid will allow as certifiable FFS expenditures. This amount is shown in the summary page of "Total Paid Claims" on the Remittance Advice (RA) and should be equal to the total in the column marked "Payable Charge".
2. **Total Medicaid Receipts** - The amount of Federal Funds received in support of the FFS program. This amount is shown in the summary page of "Total Paid Claims" on the Remittance Advice (RA) and should be equal to the total in the column marked "Paid Amount".
3. **Non-Federal Match Required** – These are the state funds that the LEA must identify. The amount is equal to the Total Medicaid expenses allowable (#1) less the Total Medicaid Receipts (#2).
4. **Non-Federal Match Funds** – Designate the source and the amount of funds in your school budget that you are using to match the federal funds received by Medicaid. This amount should be equal to the amount in #3.
5. The School's Fiscal Budget Officer must sign and date the form, certifying the accuracy and completeness of the amounts listed.